

Comparative Study on Immediate Versus Delayed Meniscus Allograft Transplantation: Reply to Response

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Dear Editor:

We read with interest the article by Jiang and colleagues¹ entitled “Comparative Study on Immediate Versus Delayed Meniscus Allograft Transplantation: 4- to 6-Year Follow-Up” and expressed our comments to the authors (Frank et al²). In turn, the authors subsequently responded (Jiang et al³) to our original letter, and we would like to take this opportunity to comment on their response. We appreciate the explanations provided related to the original study,¹ however, we have some additional comments for the authors.

In their response, the authors stated that immediate meniscus allograft transplantation (MAT) was only performed in patients with a “strong request,” despite the fact that their department did not recommend preventative MAT. They also implied that this “strong request” was the reason for the difference in follow-up duration between the immediate MAT (IM) and delayed meniscectomy (DE) groups (IM group with an average 21-month shorter follow-up duration than ME group), which, as we noted previously, likely plays a substantial role in the significantly improved International Knee Documentation Committee scores in seen in the IM group compared to the DE group.

As health care providers, we believe it is important to ensure that doctor-patient dialogues and patient-centered decision making remain as objective as possible. Specifically, indications for procedures that have limited availability, significant cost, and associated complications need to remain strict to benefit the patients that need them most. In our opinion, the most important consideration when evaluating this difficult patient population is *determining if a given patient is properly indicated* for surgery, and certainly, it is critical for the surgeon to lead the discussion and provide appropriate counseling and education. Our job is to educate the patient to the point where a proper informed decision can occur. Given limitations in graft availability, the cost of MAT, the rehabilitation requirements, and the potential complications combined with the absence of additional evidence supporting MAT

as a procedure that prevents the development of postoperative (ie, postmeniscectomy) arthritis, it remains difficult to recommend this surgery in asymptomatic patients. Even more relevant is that once a patient undergoes a MAT, to prevent subsequent allograft injury, most restrict their activities to those considered “meniscus friendly,” which would not be the case if they undergo simply meniscectomy. Thus, when patients are objectively armed with this information, one would anticipate that patient-driven requests for MAT would be relatively rare.

In the authors’ series, 8 patients in the IM group became “very anxious about the possible occurrence of postoperative osteoarthritis,” prompting them to request MAT. Specifically, it is not clear if any objective data separated these patients from the other patients who underwent meniscectomy during this time frame and never requested surgery. Likely this introduces selection bias.

Overall, we are advocates of performing MAT for appropriately indicated patients, and we agree with the authors that more research is needed with respect to determining the “at risk” patient population that is unable to cope following meniscectomy. We again applaud the authors on their comprehensive evaluation of what remains an extremely challenging patient population for even the most experienced of orthopaedic surgeons. We caution readers of the article who may otherwise extrapolate these clinical results to all patients undergoing meniscectomy, as the literature currently does not advocate for performing immediate MAT on asymptomatic patients.

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